MDR Tracking Number: M5-04-0112-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 09-08-03. Per Rule 133.308(e)(1) dates of service 09-03-02 through 09-05-02 were not timely filed. Per Rule 133.304(k) dates of service 02-06-03 through 04-10-03 did not have proof of reconsideration, therefore are not eligible for review at this time.

The IRO reviewed hot or cold pack therapy, therapeutic exercises, office visits, myofascial release, special forms, massage therapy, diathermy treatment and joint mobilizations rendered from dates of service 09-17-02 through 10-14-02 and 11-26-02 through 01-06-03 that was denied based upon "V".

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Consequently the requestor is not owed a refund of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-10-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

Codes 420, 504 and 402 are unrecognized codes per 96 MFG and therefore will not be addressed.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
10-15-02 to 10-31-02 (7 DOS)	99212	$315.00 ($45.00 (1 unit X 7 DOS)	$0.00	D	$32.00	Rule 133.307 (g)(3)(A-F)	The requestor submitted relevant information to support delivery of service. Reimbursement is recommended in the amount of $32.00 X 7 DOS = $224.00
10-15-02 to 10-31-02 (7 DOS)	97250	$315.00 ($45.00 1 unit X 7 DOS)	$0.00	D	$43.00	Rule 133.307 (g)(3)(A-F)	The requestor submitted relevant information to support delivery of service. Reimbursement is recommended in the amount of $43.00 X 7 DOS = $301.00
10-15-02 to 10-28-02 (5 DOS)	97024	$150.00 ($30.00 1 unit X 5 DOS)	$0.00	D	$21.00	Rule 133.307 (g)(3)(A-F)	The requestor submitted relevant information to support delivery of service. Reimbursement is recommended in the amount

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
							of $21.00 X 5 DOS = $105.00
10-15-02 to 2-3-03 (17 DOS)	97110	$1,190.00 ($70.00 2 units X 17 DOS)	$0.00	D, No EOB	$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
10-21-02 to 2-3-03 (11 DOS)	99212	$495.00 ($45.00 1 unit X 11 DOS)	$0.00	No EOB	$32.00	Rule 133.307 (g)(3)(A-F)	The requestor submitted relevant information to support delivery of service. Reimbursement is recommended in the amount of $32.00 X 11 DOS = $352.00
10-21-02 to 2-3-03 (10 DOS)	97250	$450.00 ($45.00 X 1 unit X 10 DOS)	$0.00	No EOB	$43.00	Rule 133.307 (g)(3)(A-F)	The requestor submitted relevant information to support delivery of service. Reimbursement is recommended in the amount of $43.00 X 10 DOS = $430.00
10-21-02 to 1-20-03 (5 DOS)	97024	$150.00 ($30.00 X 1 unit X 5 DOS)	$0.00	No EOB	$21.00	Rule 133.307 (g)(3)(A-F)	The requestor submitted relevant information to support delivery of service. Reimbursement is recommended

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
							in the amount of $21.00 X 5 DOS = $105.00
TOTAL		$5,768.00	$0.00		$227.00		The requestor is entitled to reimbursement in the amount of $1,517.00

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

This Decision is hereby issued this 9th day March 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 09-17-02 through 02-03-03 in this dispute.

This Order is hereby issued this 9th day of March 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 3/3/03

MDR Tracking Number: M5-04-0112-01

October 31, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Sincerely,

CLINICAL HISTORY
The patient sustained a compensable injury to his left shoulder on ___ when he was cutting down a tree and a branch fell and struck his left shoulder. Following a conservative treatment trial, he eventually underwent an initial left shoulder surgery in February 2002, and a subsequent one in August 2002.

REQUESTED SERVICE(S)
Hot or cold packs, therapeutic exercises, office visits, myofascial release, spec forms, massage therapy, diathermy treatment, and joint mobilizations from dates of service 9/17/02 through 10/14/02 and 11/26/02 through 1/6/03.

DECISION
All services from 9/17/02 through 10/1/02 are approved.

Joint mobilization (97265) performed with diathermy (97024) on DOS 12/31/02; and, the joint mobilizations (97265) performed alone on DOS 1/2/03 is approved.

All other services are denied.

RATIONALE/BASIS FOR DECISION
The patient was seen post-operatively at ___ office (by ___, MD) on 9/4/02; on that visit, it was recommended that ___ "continue physical therapy 4x/week for 4 weeks." Due to the proximity to the second surgery, these treatments appear reasonable and medically necessary, and are therefore approved. However, subsequent examination records from that office fail to document additional substantive

improvement after the 10/1/02 encounter. Therefore, these therapy treatments are denied.

In May 2002, ___, A TWCC-Approved designated doctor, deemed ___ MMI with a 15% whole-person impairment derived solely from the left shoulder. Then, in revisit during January 2003 – and, after the second surgery – ___ again saw the patient and awarded 22% whole-person impairment. In addition, ___ was seen on June 10, 2003 by ___, for an independent medical evaluation. In his report, ___ opined that "…it would be likely that [___] will require maintenance care for his shoulder on an indefinite basis," and that "…the effects of this injury will never resolve themselves completely."

Due to his conclusions, as well as the significant permanent impairment award by the designated doctor, it is reasonable to approve visits that address continued joint mobilization (with the deep heat performed in conjunction with it). However, in the face of little or no demonstrated and documented response to the other forms of therapy applied during the DOS in dispute, their medical necessity is not documented.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 3rd day of March 2003.